

# CLIENT INFORMATION FORM

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Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential as outlined in the Consent Form. If you do not desire to answer any question, please indicate that you do not care to answer. Please print or write clearly and bring this form with you to the next session.

**NAME:** \_\_\_\_\_ **MALE/FEMALE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE: Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Highest Grade/Degree:** \_\_\_\_\_

**Who referred you for therapy?** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Person and Phone Number to call in Emergency:** \_\_\_\_\_

**Your Occupation/Position:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**INSURANCE CO./Policy Number/Information:** \_\_\_\_\_

**What is the nature of the difficulty for which you are seeking help? (Be as specific as you can:**

**When did it start, how does it affect you?)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST & PRESENT MARRIAGES (years married, names and statement about the nature of the relationship/s, i.e., friendly, distant, etc.; if divorced, date of divorce):** \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Age: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

**CHILDREN/STEPCHILDREN (names, ages, and a brief statement on your relationship with each child):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**PARENTS/STEP-PARENTS (name/age or year of death/cause of death/brief statement about the person and your relationship with them):**

Father: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Step-parents: \_\_\_\_\_  
\_\_\_\_\_

**SIBLINGS (name/age or year of death/cause of death/brief statement about your relationship):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**MEDICAL DOCTOR(S) (name/phone):** \_\_\_\_\_  
\_\_\_\_\_

**PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, illness):**

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**MEDICATION you are presently taking, and for what. Print clearly:**

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**ALCOHOL AND DRUGS. How much alcohol do you drink in a typical week? \_\_\_\_\_**

**Past/Present alcohol/drug use/abuse (include treatments, AA or NA):**

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**Suicide attempt(s) or violent behavior (describe events, ages, reasons, circumstances, etc.:**

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**FAMILY MEDICAL HISTORY (Describe any illness that runs in the family): \_\_\_\_\_**

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**FRIENDSHIPS, COMMUNITY, CHURCH, SPIRITUALITY (Describe activities, frequency, quality):**

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**PAST/PRESENT PSYCHOTHERAPY (Specify therapist's name and phone #, estimated number of sessions, reason for therapy, Individ./Couple/Family, dates of therapy, brief description, how helpful therapy was):**

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Use other side of the page for more information about psychotherapists.**

**Describe your childhood in general (relationships with parents, siblings, school, neighborhood, relocations, behavioral problems, family problems):**

**IF PARENTS DIVORCED, your age at the time \_\_\_\_\_. Describe how it affected you at the time:**

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**FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, hospitalization, depression,):**

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**Was there alcohol abuse, physical abuse or sexual abuse in your family? If yes, please describe:**

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**What characteristics of your parent's relationship stand out in your mind?**

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**What gives you most joy or pleasure in your life?**

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**What are your main worries and fears?**

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**What are your most important hopes or dreams?**

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**Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.**